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**2000**STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE

PURPOSE AS OUTLINED IN 210 ILCS 49/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 00	07781		II. CERTI	FICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: Columbus Manor Reside			I hav	re examined the contents of the accompanying report to the
	Address: 5107 West Jackson Boulevard Number	Chicago	Zip Code		f Illinois, for the period from 1/1/00 to 12/31/00 tity to the best of my knowledge and belief that the said contents
	County: Cook	City	Zip Code	are true	iny to the best of my knowledge and belief that the said contents , accurate and complete statements in accordance with ble instructions. Declaration of preparer (other than provider)
	Telephone Number: 773-378-5490	Fax # 773-378-7860			d on all information of which preparer has any knowledge.
	IDPA ID Number: 36-2673116001				ntional misrepresentation or falsification of any information cost report may be punishable by fine and/or imprisonment.
	Date of Initial License for Current Owners:	June 17, 1999		Officer or	(Signed)
	Type of Ownership:			Administrator	(Type or Print Name) Patrick J. O'Brien (Date)
	VOLUNTARY,NON-PROFIT	X PROPRIETARY	GOVERNMENTAL	of Provider	(Title) Administrator
	Charitable Corp. Trust	Individual	State		(C: I)
	IRS Exemption Code	Partnership Corporation	County Other		(Signed) (Date)
		X "Sub-S" Corp.		Paid	(Print Name
		Limited Liability Co.		Preparer	and Title) See Attached Compilation Report
		Trust Other			(Firm Name Zoller, Swanson & Co. CPAs
					& Address) 125 N. Marion, Oak Park, IL 60301
					(Telephone) 708-763-9647 Fax #708-763-8852
	In the event there are further questions about Name: Patrick J. O'Brien	this report, please contact: Telephone Number: 773-378	8_5490		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East
	Name. 1 atticks. O Ditti	Telephone Number:	0-0-70		Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Facil	lity Name & ID Numb	oer Columbus Ma	anor Residential Ca	are Home			# 0007781 Report Period Beginning: 1/1/00 Ending: 12/31/00
	III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/o	certification level(s) of	care; enter numbe	er of beds/bed days,			973 (Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	change in licensed	beds			· · · · · · · · · · · · · · · · · · ·
	` 8	,		_		_	E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
					1		None
	Beds at				Licensed		
	Beginning of	Licensui	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census?
	Report Period	Level of C		Report Period	Report Period		1. Does the facility maintain a daily intulight census.
	Report 1 eriou	Level of	ait	Keport i eriou	Keport i eriou		G. Do pages 3 & 4 include expenses for services or
-1		Skilled (SNF	7)			1	investments not directly related to patient care?
2			atric (SNF/PED)			2	YES X NO
3	189	Intermediate	,	189	68,985	3	TES A NO
4	107	Intermediate	` /	107	00,703	4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5		Sheltered Ca				5	YES X NO
6		ICF/DD 16 o	. ,			6	The A state of the
U		101700 100	n Less			-	I. On what date did you start providing long term care at this location?
7	189	TOTALS		189	68,985	7	Date started 0/0/66
	<u> </u>				1 27 22		
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	r the entire report peri	iod.				YES X Date 05/01/79 NO
	1	2	3	4	5		
	Level of Care	Patient Days	by Level of Care at	nd Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid		1	T		YES NO X If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified and days of care provided
8	SNF	•	v			8	· · ·
9	SNF/PED					9	Medicare Intermediary None
10	ICF	65,335			65,335	10	•
	ICF/DD	/			12)200	11	IV. ACCOUNTING BASIS
12	SC					12	MODIFIED
13	DD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14	TOTALS	65,335			65,335	14	Is your fiscal year identical to your tax year? YES X NO
	C Domac-+ O-	cupancy. (Column 5, l	lina 14 dividad b-: 4	atal licensed			Tax Year: 12/31/00 Fiscal Year: 12/31/00
		cupancy. (Column 5, 1 n line 7, column 4.)	iine 14 aividea by t 94.71%	otai ncenseu			* All facilities other than governmental must report on the accrual basis.
	bed days of		74,7170	_			In memors other than governmental must report on the accidal basis.

STATE OF ILLINOIS					
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Page 3 12/31/00 STATE OF ILLINOIS # 0007781 Facility Name & ID Number Columbus Manor Residential Care Home **Report Period Beginning:** 1/1/00 **Ending:** 

V. COST CENTER EXPENSES (throu		<u>, please round t</u> Costs Per Gener		ollar)	Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
A. General Services	1	2	3	4	5	6	7	8	9	10	
1 Dietary	121,852	25,248	7,391	154,491	_	154,491		154,491	-	-	1
2 Food Purchase		283,514	,	283,514	(21,972)	261,542		261,542			2
3 Housekeeping	74,163	11,581	4,462	90,206	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	90,206		90,206			3
4 Laundry	21,710	16,115	1,407	39,232		39,232		39,232			4
5 Heat and Other Utilities			93,139	93,139		93,139		93,139			5
6 Maintenance	81,796	8,857	133,826	224,479		224,479		224,479			6
7 Other (specify):*											7
8 TOTAL General Services	299,521	345,315	240,225	885,061	(21,972)	863,089		863,089			8
B. Health Care and Programs											
9 Medical Director											9
10 Nursing and Medical Records	698,349	10,582	21,959	730,890		730,890		730,890			10
10a Therapy											10a
11 Activities	116,390	571	69,852	186,813		186,813		186,813			11
12 Social Services	70,173		21,674	91,847		91,847		91,847			12
13 Nurse Aide Training											13
14 Program Transportation											14
15 Other (specify):*											15
16 TOTAL Health Care and Programs	884,912	11,153	113,485	1,009,550		1,009,550		1,009,550			16
C. General Administration											
17 Administrative	88,576			88,576		88,576		88,576			17
18 Directors Fees											18
19 Professional Services			42,304	42,304		42,304		42,304			19
20 Dues, Fees, Subscriptions & Promotions			9,709	9,709		9,709		9,709			20
21 Clerical & General Office Expenses	76,943		46,547	123,490		123,490	(2,303)	121,187			21
22 Employee Benefits & Payroll Taxes			118,858	118,858	21,972	140,830		140,830			22
23 Inservice Training & Education											23
24 Travel and Seminar								·		`	24
25 Other Admin. Staff Transportation			8,262	8,262		8,262	(600)	7,662		`	25
26 Insurance-Prop.Liab.Malpractice			83,203	83,203		83,203	(23,838)	59,365		`	26
27 Other (specify):* Contributions			6,390	6,390		6,390	(6,390)				27
28 TOTAL General Administration	165,519		315,273	480,792	21,972	502,764	(33,131)	469,633			28
TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,349,952	356,468	668,983	2,375,403		2,375,403	(33,131)	2,342,272			29

\*\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

# V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			31,021	31,021		31,021		31,021			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			78,586	78,586		78,586		78,586			33
34	Rent-Facility & Grounds			120,000	120,000		120,000	(120,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* IL SALES TAX			20,816	20,816		20,816		20,816			36
37	TOTAL Ownership			250,423	250,423		250,423	(120,000)	130,423			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		7,597	1,105	8,702		8,702		8,702			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,316	108,316		108,316		108,316			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		7,597	109,421	117,018		117,018		117,018			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,349,952	364,065	1,028,827	2,742,844		2,742,844	(153,131)	2,589,713			45

<sup>\*</sup>Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Report Period Beginning:

1/1/00

Ending:

Page 5 12/31/00

4

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

# 0007781

	NON-ALLOWABLE EXPENSES	below	1	2 Refer-	oich the particular OHF USE ONLY	ar cost
1	Day Care	S	Amount	ence	S	1
2	Other Care for Outpatients	Ψ			Φ	2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals					4
5	Telephone, TV & Radio in Resident Rooms					5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation					9
10	Interest and Other Investment Income					10
11	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax		(2,303)	C21-3		13
14	Non-Care Related Interest		* * * * * * * * * * * * * * * * * * * *			14
15	Non-Care Related Owner's Transactions					15
16	Personal Expenses (Including Transportation)		(600)	C25-3		16
17	Non-Care Related Fees					17
18	Fines and Penalties					18
19	Entertainment					19
20	Contributions		(6,390)			20
21	Owner or Key-Man Insurance		(23,838)	C26-3		21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt					24
25	Fund Raising, Advertising and Promotional					25
26	Income Taxes and Illinois Personal					•
26	Property Replacement Tax					26
27						27 28
28 29	Yellow Page Advertising Other-Attach Schedule				1	28
30		¢.	(22 121)		•	30
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(33,131)		\$	30

	HF USE ONLY				
48	49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	-	-	
	Amount	Reference	
Non-Paid Workers-Attach Schedule*	\$	3	31
Donated Goods-Attach Schedule*		3	32
Amortization of Organization &			
Pre-Operating Expense		3	33
Adjustments for Related Organization			
Costs (Schedule VII)	(226,667)	SCH VII 3	34
Other- Attach Schedule		3	35
SUBTOTAL (B): (sum of lines 31-35)	\$ (226,667)	3	36
(sum of SUBTOTALS			
TOTAL ADJUSTMENTS (A) and (B))	\$ (259,798)	3	37
	Donated Goods-Attach Schedule* Amortization of Organization & Pre-Operating Expense Adjustments for Related Organization Costs (Schedule VII) Other- Attach Schedule SUBTOTAL (B): (sum of lines 31-35) (sum of SUBTOTALS	Non-Paid Workers-Attach Schedule*  Donated Goods-Attach Schedule*  Amortization of Organization & Pre-Operating Expense  Adjustments for Related Organization Costs (Schedule VII) (226,667) Other- Attach Schedule  SUBTOTAL (B): (sum of lines 31-35) \$ (226,667)	Non-Paid Workers-Attach Schedule*  Donated Goods-Attach Schedule*  Amortization of Organization & Pre-Operating Expense  Adjustments for Related Organization Costs (Schedule VII) (226,667) SCH VII Other- Attach Schedule  SUBTOTAL (B): (sum of lines 31-35) \$ (226,667)

<sup>\*</sup>These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

1 2 3

	,	Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
	Barber and Beauty Shops					41
	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

| STATE OF ILLINOIS
| Columbus Manor Residential Care Home | 1109 | 0007781 |
| Report Period Beginning: | 11/100 |
| Ending: | 12/31/00 | Page 5A

Sch. V Line Amount Reference

NON-/	ALLOWABLE EXPENSES	Amount	Reference	
1		S		1
2				3
4				4
5				5
7			-	7
8			-	8
9				9
10				10
11				1
12				12
13				13
14				14
15				15
16				10
17				1
18				1
19				19
20				2
21				2
22				2
23				2.
24				2
25				2:
26				2
27				2
28				2
29				2
30				3
31				3
32			<del>                                     </del>	3
33				3.
34			-	3.
25				3
35 36			-	3:
37				3
38				3
38				
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40				40
41				4
42				42
43				43
44				44
45				45
46				44
47				4
48				4
49				4
50				5
51				5
52				5.
53				5.
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57				5
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87 88				
87		0		8 8 9

STATE OF ILLINOIS

Summary A # 0007781 Report Period Beginning: 1/1/00 12/31/00 Ending:

Facility Name & ID Number Columbus Manor Residential Care Home SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61

													SUMMARY
	ting Expenses	PAGES	PAGE	TOTALS									
A. Genera	l Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)
1 Dietary		0	0	0	0	0	0	0	0	0	0	0	0
2 Food Purc		0	0	0	0	0	0	0	0	0	0	0	0 2
3 Housekeep	ping	0	0	0	0	0	0	0	0	0	0	0	0 3
4 Laundry		0	0	0	0	0	0	0	0	0	0	0	0 4
	Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6 Maintenan		0	0	0	0	0	0	0	0	0	0	0	0 (
7 Other (spe	ecify):*	0	0	0	0	0	0	0	0	0	0	0	0 2
8 TOTAL C	General Services	0	0	0	0	0	0	0	0	0	0	0	0 8
B. Health	Care and Programs												
9 Medical D	irector	0	0	0	0	0	0	0	0	0	0	0	0 9
10 Nursing ar	nd Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 1
10a Therapy		0	0	0	0	0	0	0	0	0	0	0	0 1
11 Activities		0	0	0	0	0	0	0	0	0	0	0	0 1
12 Social Ser	vices	0	0	0	0	0	0	0	0	0	0	0	0 1
13 Nurse Aid	e Training	0	0	0	0	0	0	0	0	0	0	0	0 1
14 Program T	ransportation	0	0	0	0	0	0	0	0	0	0	0	0 1
15 Other (spe	ecify):*	0	0	0	0	0	0	0	0	0	0	0	0 1
16 TOTAL H	lealth Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0 1
C. General	l Administration												
17 Administra	ative	0	0	0	0	0	0	0	0	0	0	0	0 1
18 Directors I	Fees	0	0	0	0	0	0	0	0	0	0	0	0 1
19 Profession	al Services	0	0	0	0	0	0	0	0	0	0	0	0 1
	scriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0 2
21 Clerical &	General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0 2
22 Employee	Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 2
23 Inservice	Fraining & Education	0	0	0	0	0	0	0	0	0	0	0	0 2
24 Travel and	l Seminar	0	0	0	0	0	0	0	0	0	0	0	0 2
25 Other Adn	nin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 2
26 Insurance-	Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 2
27 Other (spe	ecify):*	0	0	0	0	0	0	0	0	0	0	0	0 2
28 TOTAL G	Seneral Administration	0	0	0	0	0	0	0	0	0	0	0	0 2
	perating Expense	_		_		_			_		_	_	
29 (sum of lin	nes 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0 2

STATE OF ILLINOIS

Summary B Facility Name & ID Number Columbus Manor Residential Care Home # 0007781 Report Period Beginning: 1/1/00 **Ending:** 12/31/00

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	TOTALS								
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 <b>G</b>	6H	6I	(to Sch V, col.	7)
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

1/1/00

**Ending:** 

12/31/00

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

miles and res	atou organiz	ationo (partico) ao aomitoa in tin	o motraotionoi / titaon o	an additional softcadic it hosessary.				
		2		3				
		RELATED NURSING HOME	ES	OTHER RELATED BUSINESS ENTITIES				
Ownership %	Name		City	Name	City		Type of Business	
			2 RELATED NURSING HOME	2 RELATED NURSING HOMES	2 RELATED NURSING HOMES OTHER RELA	2 3 RELATED NURSING HOMES OTHER RELATED BUSINESS		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
					-	Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V		Rent	\$ 120,000	CMLLC	0.00%	<b>\$</b> (120,000)	\$ (240,000)	1
2	V		Depreciation		CMLLC	0.00%	13,333	13,333	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V						·		11
12	V								12
13	V		_		_	· ·			13
14	Total			\$ 120,000			\$ (106,667)	\$ * (226,667)	14

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7 Facility Name & ID Number Columbus Manor Residential Care Home 0007781 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

#### VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Hou	ırs Per Work				
					Compensation	Week Deve	oted to this	Compensatio	on Included	Schedule V.	
					Received	Facility and	l % of Total	in Costs for this		Line &	
				Ownership	From Other	Work Week		Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Patrick J. O'Brien	Administrator	CEO/Administrato	0.00	None	40	1.00	Salary & Bonu	\$ 88,576	17-4	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 88,576		13

<sup>\*</sup> If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

<sup>\*\*</sup> This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Columbus Manor Residential Care Home # 0007781 Report Period Beginning: 1/1/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)  YES  NO  X	City / State / Zip Code	
	Phone Number ( )	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number ( )	

D. Show the anocation of costs below.	ii necessary, picase attacii	worksneets.

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	reference	Tem .	Square recej	Total Clits	7 mocateu 7 mong	\$	\$	Chits	\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13 14										13 14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		s	25

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
										Reporting	
				Monthly				Maturity	Interest	Period	
	Name of Lender	Related**	Purpose of Loan	Payment	Date of	Amou	int of Note	Date	Rate	Interest	
		YES NO		Required	Note	Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related										
	Long-Term										
1						\$	\$			\$	1
2											2
3											3
4											4
5											5
	Working Capital										
6											6
7											7
8											8
9	TOTAL Facility Related					\$	\$			\$	9
	B. Non-Facility Related*							_			
10											10
11											11
12											12
13											13
14	TOTAL Non-Facility Related					\$	\$			\$	14
15	TOTALS (line 9+line14)					\$	\$			\$	15

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Columbus Manor Residential Care Home

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

B. Real Estate Taxes				-		_				
1. Real Estate Tax accrual used on 1999 repor	t.			s	78,537	1				
2. Real Estate Taxes paid during the year: (Inc	dicate the tax year to which this payment applies. If payment co	overs more than one year,	detail below.)	s	76,645	2				
3. Under or (over) accrual (line 2 minus line 1	).			s	(1,892)	3				
4. Real Estate Tax accrual used for 2000 repo	4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)									
* 1	s which has NOT been included in professional fees or other generated copies of invoices to support the cost and a compact to the cost and a contract to the cost and a cost a cost and a cost a cost a cost a cost and a cost a cos	1 0		\$		5				
amount of any direct appeal costs classified	oreviously to calculate a payment rate. You must offset the full as a real estate tax cost plus one-half of any remaining refund.  For 19 Tax Year. (Attach a copy of the refundation of		board's decision.)	s		6				
7. Real Estate Tax expense reported on Sched	ule V, line 33. This should be a combination of lines 3 thru 6.			\$	78,586	7				
Real Estate Tax History:										
Real Estate Tax Bill for Calendar Year:	1995 64,463 8		FOR OHF USE ONLY							
	1996 66,049 9 1997 75,817 10	13	FROM R. E. TAX STATEMENT FO	OR 1999 \$		13				
	1998 83,999 11 1999 76,645 12	14	PLUS APPEAL COST FROM LINE	<b>≣</b> 5 <b>\$</b>		14				
		15	LESS REFUND FROM LINE 6	\$		15				
		16	AMOUNT TO USE FOR RATE CA	LCULATION\$		16				

NOTES:

- ${\bf 1.} \ \ {\bf Please\ indicate\ a\ negative\ number\ by\ use\ of\ brackets(\ ).\ \ Deduct\ any\ over accrual\ of\ taxes\ from\ prior\ year.$
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
  application for real estate tax exemption unless the building is rented from a for-profit entity.
  This denial must be no more than four years old at the time the cost report is filed.

	ity Name & ID Number Columbus Ma JILDING AND GENERAL INFORMA			STATE OF ILLINO # 0007781		eriod Beginning:		1/1/00 E	Ending:	Page 11 12/31/00
A.	Square Feet: 41,308	B. General Construction Type:	Exterior	Brick	Frame	Fire Resistant		Number of Storie	es	2
c.	Does the Operating Entity?	(a) Own the Facility	x (b) Rent from	a Related Organizatio	on.			Rent from Compl Organization.	letely Unrela	ated
	(Facilities checking (a) or (b) must co	mplete Schedule XI. Those checking (c)	may complete Sched	ule XI or Schedule XII	-A. See inst	ructions.				
D.	Does the Operating Entity?	x (a) Own the Equipment	(b) Rent equi	pment from a Related	Organizatio	n.		Rent equipment f Unrelated Organi		etely
	(Facilities checking (a) or (b) must co	mplete Schedule XI-C. Those checking	(c) may complete Sch	edule XI-C or Schedule	e XII-B. See	instructions.		8		
E.	(such as, but not limited to, apartmen	by this operating entity or related to th its, assisted living facilities, day training uare footage, and number of beds/units	g facilities, day care, ii	ndependent living facili						
F.	Does this cost report reflect any organif so, please complete the following:	nization or pre-operating costs which a	re being amortized?			YES	x N	NO		
1.	Total Amount Incurred:			2. Number of Years	Over Which	it is Being Amort	ized:			
3.	<b>Current Period Amortization:</b>			4. Dates Incurred:						
		Nature of Costs: (Attach a complete schedule deta	iling the total amount	t of organization and p	re-operating	g costs.)				
XI. O	WNERSHIP COSTS:									
		1	2	3		4				
	A. Land.	Use	Square Feet	Year Acquired	•	Cost	1			

41,988

# 0007781 Report Period Beginning:

1/1/00 Ending: Page 12 1/2/31/00

Facility Name & ID Number Columbus Manor Residential Care Home # 000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar

	B. Buildin	g Depreciation-Including Fixed Equi	ipment. (See instr	uctions.) Roun	d all numi	pers to nea	arest dollar					
	1		2	3		4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year			Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	129		1965	1955	S	179,090	\$	30	\$	\$	<b>\$</b> 179,090	4
5	12			1969		67,135		30			67,135	5
6	48		1969	1973	4	401,170	13,372	30	13,372		367,737	6
7							-		·			7
8												8
	Improv	vement Type**	_									
9	Additions	**		1972		89,417	2,981	30	2,981		88,067	9
10	Additions			1974		30,006	1,000	30	1,000		26,503	10
11	Additions			1976		14,351	478	30	478		11,714	11
12	Sidewalk			1966		1,309		20			1,309	12
13	Sidewalk			1967		1,819		20			1,819	13
14	Fence			1970		5,795		15			5,795	14
	Remodeling			1970		26,600	384	30	384		26,600	15
	Sprinkler			1971		39,406		25			39,406	16
	Tile Flooring			1971		12,097		20			12,097	17
	Stairs Prock E			1972		19,211	640	30	640		18,245	18
19	Roofing Repla	ced		1972		3,783	126	30	126		3,592	19
	Canopy			1972		1,339		20			1,339	20
	Fencing			1972		2,016		15			2,016	21
22	Tile Floors			1973		4,718		20			4,718	22
23	Chain Link Fe			1974		3,589		15			3,589	23
	Sprinkler Syst			1974		4,664		25			4,664	24
	Nurses Station			1975		15,635		20			15,635	25
26	Switching Tilin			1975		13,706		20			13,706	26
27	Plumbing and			1976		20,000	800	25	800		19,600	27
	Tile and Toilet	S		1976		39,685		20			39,685	28
29	Sprinkler			1976		1,868	75	25	75		1,835	29
	Tops and Caul	king		1976		52,683		20			52,683	30
	Tile			1976		6,796		20			6,796	31
	Retile Building			1977	ļ	53,525		20			53,525	32
33	Plastering			1977	ļ	10,920		20			10,920	33
	Carpentry			1978		5,152		20			5,152	34
	Tile			1978		11,775		20			11,775	35
36	TOTAL (line	s 4 thru 35)			\$ 1,1	139,260	\$ 19,856		\$ 19,856	\$	\$ 1,096,747	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.
\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Columbus Manor Residential Care Home # 000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar

	B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar													
	1		2	3	4	5	6	7	8	9				
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated				
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation				
4					\$	\$		\$	\$	\$	4			
5											5			
6											6			
7											7			
8											8			
	Impr	ovement Type**							•					
9	Tuckpointing			1980	5,600	140	20	140		5,600	9			
10	Hot Water H	eater		1981	971	49	20	49		942	10			
11	Doors, Etc.			1981	1,360	68	20	68		1,326	11			
12	Ceramic Tile			1981	24,262	1,213	20	1,213		23,655	12			
13	Additions			1982	14,743	737	20	737		13,635	13			
	Windows			1983	13,166	658	20	658		11,517	14			
	Windows			1987	2,365	118	20	118		1,595	15			
	Cameras			1987	1,091	55	20	55		738	16			
	Roof Improv	ement		1988	3,700	185	20	185		2,312	17			
	Heater			1990	1,240	124	10	124		1,302	18			
	Doors, Etc.			1990	3,543	177	20	177		1,860	19			
	Electrical			1990	2,202	110	20	110		1,156	20			
	Exit Doors			1991	19,211	961	20	961		9,126	21			
	Doors			1991	14,655	733	20	733		6,962	22			
	Electrical			1991	3,507	175	20	175		1,665	23			
	New Door			1992	1,330	67	20	67		566	24			
	Roof			1992	8,950	448	20	448		3,805	25			
	Windows	D		1992	3,150	158	20	158		1,340	26			
	Exit/Interior			1993	6,100	305	20	305		1,984	27			
	Remodel Nur Outside Door			1994 1994	16,000 2,882	800 144	20 20	800 144		5,600	28 29			
	Remodel Nur			1994	2,882	1.015	20	1,015		1,009 7,105	30			
	Roof Replace			1994	20,300	1,015	20	1,015	1	7,105 8,626	31			
	Remodel Nur			1995	17,710	886	20	886		5,314	32			
	Generator	se s Station		1998	80,000	8,000	10	8,000	-	24,000	33			
	Air Condition	ner/Monitor		1998	2,098	210	10	210	-	630	34			
	Hydra Electr			1999	900	45	20	45		90	35			
		es 4 thru 35)		1///	\$ 299,787	s 19.019	20	\$ 19,019	¢	\$ 143,460	36			
20	TOTAL (IIII	co + un u 33)			g 477,101	g 17,017		U 17,017	Ψ	g 173,700	50			

<sup>\*</sup>Total beds on this schedule must agree with page 2.
\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Page 12B 12/31/00 Report Period Beginning: 1/1/00 Ending:

Facility Name & ID Number Columbus Manor Residential Care Home # 00077

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	B. Bullal	ng Depreciation-Including Fixed Equ		uctions.) Roun		rest dollar					
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		ovement Type**									
	DeCarlo Con			1999	4,900	245	20	245		490	9
	Storm Windo	ows		1999	6,059	303	20	303		606	10
	Wall Repair			1999	3,098	155	20	155		310	11
	AC Prep			1999	1,824	92	20	92		184	12
	New Fans			1999	1,932	97	20	97		194	13
	AC Prep			1999	2,168	109	20	109		218	14
	Exhaust Fans	i		1999	9,450	473	20	473		946	15
	Radiator			2000	10,900	545	20	545		545	16
	PTAK Unit			2000	8,606	430	20	430		430	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30 31											30
											31
32						ļ					32
											33
34											34
35	TOTAL C				e 40.027	0 2.440		0 2.440		2 022	35
36	TOTAL (lin	es 4 thru 35)			\$ 48,937	\$ 2,449		\$ 2,449	\$	\$ 3,923	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.
\*\*Improvement type must be detailed in order for the cost report to be considered complete.

STA	TE	OF	II	IΤ	NOIS

		Page 13
Facility Name & ID Number Columbus Manor Residential Care Home # 0007781 Report Period Beginning: 1/1/00	Ending:	12/31/00

# XI. OWNERSHIP COSTS (continued)

C. Equipment	Depreciation-Excluding	Transportation.	(See instructions.)

	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
37	Purchased in Prior Years	\$ 992,264	\$ 44,812	\$ 44,812	\$	10/30	\$ 782,203	37
38	Current Year Purchases	5,066	254	254		10	254	38
39	Fully Depreciated Assets	477,982				15/20	477,982	39
40								40
41	TOTALS	\$ 1,475,312	\$ 45,066	\$ 45,066	\$		\$ 1,260,439	41

#### D. Vehicle Depreciation (See instructions.)\*

	Î Î	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
42	Non Care Related	Cadillac '92	1997	\$ 25,344	\$ 2,534	\$ 2,534	\$	5	\$ 10,136	42
43	Facility Business	Ford '94	1993	23,204					23,204	43
44										44
45										45
46	TOTALS			\$ 48,548	\$ 2,534	\$ 2,534	\$		\$ 33,340	46

## F Summery of Cara-Related Assets

		E. Summary of Care-Related Assets	1		4		
I			Reference		Amount		]
	47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$	3,045,844	47	
	48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$	88,924	48	
	49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$	88,924	49	**
	50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$		50	
ı	51	Accumulated Depreciation	(line 36 col 9 + line 41 col 6 + line 46 col 9)	S	2.537.909	51	1

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

		1	2	Curre	nt Book	Acc	cumulated	
		Description & Year Acquired	Cost	Depre	ciation 3	Dej	preciation 4	
ſ	52	92 Cadillac/Purchased 1997	\$ 25,344	\$	2,534	\$	10,136	52
ſ	53							53
ſ	54							54
ſ	55							55
ſ	56				•		•	56
Ī	57	TOTALS	\$ 25,344	\$	2,534	\$	10,136	57

## G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

<sup>\*</sup> Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

<sup>\*\*</sup> This must agree with Schedule V line 30, column 8.

Facil	lity Name & II	) Number	Columbus Manor Re	sidential Care Home		STAT #	TE OF ILLINOIS 0007781	Report P	eriod Beginnin	ng: 1/1/00	Ending:	Page 14 12/31/00
XII.	1. Name of I 2. Does the f	nd Fixed Equ Party Holding	ny real estate taxes in addi	tion to rental amount	shown below on			NO				
		1 Year Constructe	2 Number ed of Beds	3 Date of Lease	4 Rental Amount		5 Total Years of Lease	6 Total Years Renewal Option*				
	Original Building: Additions			s				•	3 I	Effective dates of cur Beginning Ending	rent rental agree	ment:
5		_							5	D 44 1 :1: 64		
7	TOTAL			\$						Rent to be paid in fut rental agreement:	ure years under	the current
	This amou	unt was calcul ngth of the lea	ortization of lease expense lated by dividing the total se				*		12. 13. 14.		<u> </u>	ent
	15. Îs Moval 16. Rental A	ble equipment mount for mo	Transportation and Fixed trental included in building to able equipment:	Equipment. (See instrugg rental?	Description:			NO detailing the breako	lown of movab	le equipment)		
	C. Vehicle Re	ental (See inst	ructions.)	3			4					
17	Use		Model Year and Make	Monthly L Paymer \$		\$	Rental Expense for this Period	17		* If there is an option please provide com		

17 18

19 20

21

schedule.

\*\* This amount plus any amortization of lease

expense must agree with page 4, line 34.

21 TOTAL

				TATE OF ILLI	NOIS						Page 15
		esidential Care Home			#	0007781	Report Perio	d Beginning:	1/1/00	Ending:	12/31/00
XIII. EX	PENSES RELATING TO NURSE AIDE TRAINING	G PROGRAMS (See in	structions.)								
<b>A.</b> 7	TYPE OF TRAINING PROGRAM (If aides are train	ned in another facility	program, attach a	schedule listing t	he facility	y name, addres	s and cost per	aide trained in th	nat facility.)		
	1. HAVE YOU TRAINED AIDES	YES 2.	CLASSROOM	PORTION:			3.	CLINICAL PO	RTION:		
	DURING THIS REPORT										
	PERIOD?	x NO	IN-HOUSE PR	OGRAM				IN-HOUSE PR	OGRAM		
			IN OTHER FA	CILITY				IN OTHER FA	CILITY		
	If "yes", please complete the remainder										
	of this schedule. If "no", provide an		COMMUNITY	COLLEGE				HOURS PER A	AIDE		
	explanation as to why this training was										
	not necessary.		HOURS PER A	AIDE							
B. 1	EXPENSES						C. COI	NTRACTUAL IN	NCOME		
		ALLOCATI	ON OF COSTS	(d)							
				(4)							
				(u)				In the box below	w record the	amount of ir	come your
		1	2	3		4		In the box below facility received			
	1	1 Fa	2 cility	, ,		4					
		1 Prop-outs		, ,		4 Total	7				
1	Community College Tuition		cility	3	\$	4 Total					
1 2	Books and Supplies		cility	3	\$	4 Total	D. NUN		l training aid		
1 2 3	Books and Supplies Classroom Wages (a)		cility	3	S	4 Total	D. NU	facility received  S MBER OF AIDE	training aid		
1 2 3 4	Books and Supplies Classroom Wages (a) Clinical Wages (b)		cility	3	\$	4 Total	D. NUN	facility received	training aid		
1 2 3 4 5	Books and Supplies Classroom Wages (a) Clinical Wages (b) In-House Trainer Wages (c)		cility	3	\$	4 Total	D. NUN	S  MBER OF AIDE  COMPLET  1. From this fac	I training aid S TRAINED EED Eility		
1 2 3 4 5 6	Books and Supplies Classroom Wages (a) Clinical Wages (b) In-House Trainer Wages (c) Transportation		cility	3	\$	Total	D. NUN	ABER OF AIDE  COMPLET 1. From this fac 2. From other fi	S TRAINED ED Edity accilities (f)		
1 2 3 4 5 6	Books and Supplies Classroom Wages (a) Clinical Wages (b) In-House Trainer Wages (c)		cility	3	\$	4 Total	D. NUM	S  MBER OF AIDE  COMPLET  1. From this fac	S TRAINED ED Edity accilities (f)		
1 2 3 4 5 6 7 8	Books and Supplies Classroom Wages (a) Clinical Wages (b) In-House Trainer Wages (c) Transportation		cility	3	\$	4 Total	D. NU	ABER OF AIDE  COMPLET 1. From this fac 2. From other fi	S TRAINED TED Cility Cacilities (f)		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

10 SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

TOTAL TRAINED

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Columbus Manor Residential Care Home

# 0007781 Report Period Beginning:

1/1/00 **Ending:** 

Page 16 12/31/00

## XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
		Schedule V	Stafi	•	Outside	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other th	an consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
	Licensed Speech and Language									
2	Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts							9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$	!	\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Page 17 12/31/00 ility Name & ID Number Columbus Manor Residential Care Home

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached. Facility Name & ID Number Report Period Beginning: **Ending:** 0007781 1/1/00

(last day of reporting year) As of 12/31/00

		1		2 After	
		C	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	725,355	\$	1
2	Cash-Patient Deposits				2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance		706,810		3
4	Supply Inventory (priced at )		1,800		4
5	Short-Term Investments				5
6	Prepaid Insurance		16,519		6
7	Other Prepaid Expenses		2,290		7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	1,452,774	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land				13
14	Buildings, at Historical Cost				14
15	Leasehold Improvements, at Historical Cost		755,645		15
16	Equipment, at Historical Cost		554,123		16
17	Accumulated Depreciation (book methods)		(984,217)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):				23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	325,551	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	1,778,325	\$	25

		1 O	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	79,613	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits				28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		30,015		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)				31
32	Accrued Real Estate Taxes(Sch.IX-B)		80,478		32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	\ <b>1</b>				36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	190,105	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$		\$	45
	TOTAL LIABILITIES				Ì
46	(sum of lines 38 and 45)	\$	190,105	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	1,097,165	\$	47
	TOTAL LIABILITIES AND EQUITY	i			
48	(sum of lines 46 and 47)	\$	1,287,270	\$	48

<sup>\*(</sup>See instructions.)

# 0007781

AVI. STATEMENT	Or CI	IANGES	IN EQUIL I

IANGES IN EQUIT I			
		-	
Dalance at Deginning of Vear, as Draviously Deported	•		1
	Э	1,097,103	2
restatements (describe).			3
			4
			5
Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	1,097,165	6
A. Additions (deductions):			
NET Income (Loss) (from page 19, line 43)		2,065,781	7
Aquisitions of Pooled Companies			8
Proceeds from Sale of Stock			9
Stock Options Exercised			10
Contributions and Grants			11
Expenditures for Specific Purposes			12
Dividends Paid or Other Distributions to Owners		(1,571,727)	13
Donated Property, Plant, and Equipment			14
Other (describe)			15
Other (describe)			16
TOTAL Additions (deductions) (sum of lines 7-16)	\$	494,055	17
B. Transfers (Itemize):			
			18
			19
			20
			21
			22
TOTAL Transfers (sum of lines 18-22)	\$		23
BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	1,591,220	24
	A. Additions (deductions):  NET Income (Loss) (from page 19, line 43)  Aquisitions of Pooled Companies  Proceeds from Sale of Stock  Stock Options Exercised  Contributions and Grants  Expenditures for Specific Purposes  Dividends Paid or Other Distributions to Owners  Donated Property, Plant, and Equipment  Other (describe)  Other (describe)  TOTAL Additions (deductions) (sum of lines 7-16)  B. Transfers (Itemize):	Restatements (describe):  Balance at Beginning of Year, as Restated (sum of lines 1-5)  A. Additions (deductions):  NET Income (Loss) (from page 19, line 43)  Aquisitions of Pooled Companies  Proceeds from Sale of Stock  Stock Options Exercised  Contributions and Grants  Expenditures for Specific Purposes  Dividends Paid or Other Distributions to Owners  Donated Property, Plant, and Equipment  Other (describe)  Other (describe)  TOTAL Additions (deductions) (sum of lines 7-16)  B. Transfers (Itemize):  TOTAL Transfers (sum of lines 18-22)	Restatements (describe):  Balance at Beginning of Year, as Restated (sum of lines 1-5)  A. Additions (deductions):  NET Income (Loss) (from page 19, line 43)  Aquisitions of Pooled Companies  Proceeds from Sale of Stock  Stock Options Exercised  Contributions and Grants  Expenditures for Specific Purposes  Dividends Paid or Other Distributions to Owners  Dividends Property, Plant, and Equipment  Other (describe)  Other (describe)  TOTAL Additions (deductions) (sum of lines 7-16)  B. Transfers (Itemize):  TOTAL Transfers (sum of lines 18-22)

<sup>\*</sup> This must agree with page 17, line 47.

Facility Name & ID Number Columbus Manor Residential Care Home

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue		Amount	
	A. Inpatient Care			
1	Gross Revenue All Levels of Care	\$	4,770,945	1
2	Discounts and Allowances for all Levels	(	)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	4,770,945	3
	B. Ancillary Revenue			
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy			6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$		8
	C. Other Operating Revenue			
9	Payments for Education			9
10	Other Government Grants			10
11	Nurses Aide Training Reimbursements			11
12	Gift and Coffee Shop		35,040	12
13	Barber and Beauty Care			13
14	Non-Patient Meals			14
15	Telephone, Television and Radio		174	15
16	Rental of Facility Space			16
17	Sale of Drugs			17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services			21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	35,214	23
	D. Non-Operating Revenue			
24	Contributions			24
25	Interest and Other Investment Income***		2,466	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	2,466	26
	E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)			27
28				28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	_	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	4,808,625	30

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	872,028	31
32	Health Care	1,009,550	32
33	General Administration	602,141	33
	B. Capital Expense		
34	Ownership	250,423	34
	C. Ancillary Expense		
35	Special Cost Centers	8,702	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,742,844	40
41	Income before Income Taxes (line 30 minus line 40)**	2,065,781	41
42	Income Taxes		42
		2015 500	4.77
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,065,781	43

*	This must agree	with page 4,	line 45, column 4.
	i nis must agree	with page 4,	, iine 45, coiumn

**	Does this agree with t	axable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation.

<sup>\*\*\*</sup> See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

<sup>\*\*\*\*</sup>Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Columbus Manor Residential Care Home

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	(This senedule must cover the	1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,960	2,280	\$ 59,280	\$ 26.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,877	5,324	105,130	19.75	3
4	Licensed Practical Nurses	16,735	18,215	259,599	14.25	4
5	Nurse Aides & Orderlies	31,773	34,998	269,249	7.69	5
6	Nurse Aide Trainees					6
	Licensed Therapist					7
	Rehab/Therapy Aides					8
9	Activity Director	1,853	1,951	19,526	10.01	9
	Activity Assistants	9,172	10,040	96,098	9.57	10
	Social Service Workers	4,398	4,540	71,712	15.80	11
	Dietician					12
	Food Service Supervisor	1,855	2,031	23,185	11.42	13
	Head Cook					14
	Cook Helpers/Assistants	10,191	11,314	97,714	8.64	15
16	Dishwashers					16
17	Maintenance Workers	5,753	6,393	81,276	12.71	17
	Housekeepers	7,364	8,260	73,798	8.93	18
19	Laundry	1,952	2,200	21,590	9.81	19
	Administrator	2,040	2,160	85,050	39.38	20
	Assistant Administrator	2,040	2,080	43,757	21.04	21
	Other Administrative	1,660	1,800	35,442	19.69	22
23	Office Manager					23
	Clerical					24
	Vocational Instruction					25
	Academic Instruction					26
	Medical Director					27
	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	103,623	113,586	s 1,342,406 *	s 11.82	34

<sup>\*</sup> This total must agree with page 4, column 1, line 45.

## B. CONSULTANT SERVICES

		1	2	3	
		Number	<b>Total Consultant</b>	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	169	\$ 5,138	1-3	35
36	Medical Director				36
37	Medical Records Consultant	286	6,581	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	1,654	43,840	11-3	44
45	Social Service Consultant	711	21,674	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,820	s 77,233		49

## C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

<sup>\*\*</sup> See instructions.

STATE OF ILLINOIS Page 21

Facility Name & ID Number	Columbus Manor I	Residential Car	re H	lome	# 000773	81	Re	port Period I	Beginning: 1/1/00 Ending	<b>;</b> :	12/31/00
XIX. SUPPORT SCHEDULES	8										
A. Administrative Salaries Name	Function	Ownership %		Amount	D. Employee Benefits and Pa Descrip	tion		Amount	F. Dues, Fees, Subscriptions and Promoti Description	ons	Amount
Patrick J. O'Brien	Administrator	0.00%	\$_	88,576	Workers' Compensation Insu		_ \$		IDPH License Fee	\$	
			_		<b>Unemployment Compensatio</b>	n Insurance	_	14,045	Advertising: Employee Recruitment		
					FICA Taxes		_	101,909	Health Care Worker Background Check	_	
					<b>Employee Health Insurance</b>		_		(Indicate # of checks performed	) _	
					<b>Employee Meals</b>		_	21,972	Business Week	_	55
					Illinois Municipal Retiremen	t Fund (IMRF)*	_		Chicago Sun Times	_	1,575
			_		City of Chicago Head Tax		_	2,904	Chicago Tribune		1,230
TOTAL (agree to Schedule V,									Clinton Chamber of Commerce		150
(List each licensed administrat	or separately.)		\$	88,576			_		Ill Council on Long Term Care		6,699
B. Administrative - Other							_		Less: Public Relations Expense	, -	
Description				Amount			_		Non-allowable advertising	} -	
Description			ø	Amount			_		Yellow page advertising	} -	
			Ф_				_		1 enow page advertising	(_	
			-		TOTAL (agree to Schedule V	v,	\$	140,830	TOTAL (agree to Sch. V,	\$	9,709
					line 22, col.8)				line 20, col. 8)	_	
TOTAL (agree to Schedule V,	line 17, col. 3)		\$		E. Schedule of Non-Cash Con	mpensation Paid			G. Schedule of Travel and Seminar**		
(Attach a copy of any managen	nent service agreemen	it)	_		to Owners or Employees						
C. Professional Services									Description		Amount
Vendor/Payee	Type			Amount	Description	Line#		Amount			
Shefsky & Frolich	Legal		\$	156			\$		Out-of-State Travel	\$	
Sochnoff & Weaver	Legal			7,331							
Zoller, Swanson & Co.	Accounting			34,817							
			_						In-State Travel	_	
			_				_			_	
	_		-				_			-	
			-				_		Seminar Expense	-	
			_				_				
			-				_			-	
			-				-		Entertainment Expense	( -	
TOTAL (agree to Schedule V,	line 19, column 3)	-	_		TOTAL		\$		(agree to Sch. V,	` -	
(If total legal fees exceed \$2500	attach copy of invoice	es.)	\$	42,304					TOTAL line 24, col. 8)	\$	
					* A44l				*****		

<sup>\*</sup> Attach copy of IMRF notifications

<sup>\*\*</sup>See instructions.

Report Period Beginning:

1/1/00

**Ending:** 

Page 22 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, 1	line 6, col. 3).

	(See instructions.)						,						
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		s		\$	\$	\$	\$	\$	\$	\$	s	s

Facility Name & ID Number Columbus Manor Residential Care Home  (1) Are nursing employees (RN,LPNA) represented by a union?  (2) Are there any dues to nursing home associations included on the cost report?  (3) If YES, give association name and amount. No  (4) Does the bed capacity of the building differ from the number of beds licensed at the early dues to uniform the number of beds licensed at the end of the fiscal year? No  (5) Have you properly capitalized all major repairs and equipment purchases?  (6) Have you properly capitalized all amount of both disposable and non-disposable diagre expense and the location of this expense on Seh. V.  (6) Have all costs reported in this form ben determined using accounting procedures consistent with prior reports?  (7) Have all costs reported in this form ben determined using accounting procedures consistent with prior reports?  (8) Are you presently operating under a sublease agreement?  (9) Are you presently operating under a sublease agreement?  (10) Was his home previously operated by a related party (as is defined in the instructions for Schedule VII)?  (11) Was his home previously operated by a related party (as is defined in the instructions for Schedule VII)?  (12) Are there amount of the Provider Participation Fees paid and accrued to the Department of Public Aid, in addition to the daily rate, been properly classifies.  (14) Is a portion of the building used for enay function of ther than long term care services to the health and intended using a portion of the building used for rank patient ceasus listed on page 2, Section B? No  (15) Indicate the coat of employee meals that has been reclassified to employee benefit:  (16) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Seh. V.  (8) Are you presently operating under a sublease agreement?  (9) Are you presently operating under a sublease agreement?  (10) Was his home previously operated by a related party (as is defined in the instructions for	F			OF ILLINOIS	B (B ( IB ( )	1/1/00	F. 11	Page 23
Are nursing employees (RN,LPN,N) represented by a union? No If YES, give association included on the cost report of If YES, give association name and amount. No If YES, give association name and amount. No If YES, give association name and amount. No If YES, and the capacity?   No   If YES, have these costs been properly adjusted out of the cost report?			#	: 0007781	Report Period Beginning:	1/1/00	Enging:	12/31/00
(2) Are there any dues to nursing home associations included on the cost report?  (3) Did the nursing home make political contributions or payments to a politica action organization? No If YES, have these costs been properly adjusted out of the cost report?  (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?  (5) Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period.  (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. S N/A Line consists that the conflict explanation.  (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.  (8) Are you presently operating under a sale and leaseback arrangement? No If YES, give effective date of lease.  (9) Are you presently operating under a sublease agreement? YES X NO Schedule VII)? YES NO X If YES, please indicate the present owners took over This amount is to be recorded on line 42 of Schedule V.  (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES No X If YES, please indicate the present owners took over This amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. S If YES, please indicate the present owners took over This amount of the provider Participation Fees paid and accrued to the Department of This related party (as is defined in the instructions for the building used for any function other than long term care services for the patient census listed on page 2, Section B? No If YES, attach a complete cuptain the patient census listed on page 2, Section B? No If YES, please indicate the mount of the building used for any function of the building used for any function of the build			(12)	II	1: 4i1:-1 £4b.	- 4 414	. 1 1.:11 . 3 4 .	
1	(1)	Are nursing employees (KN,LPN,NA) represented by a union?	(13)					
If YES, give association name and amount. No	(2)					ite, been prop	erly classified	
(14) Is a portion of the building used for any function other than long term care services for been properly adjusted out of the cost report?  (15) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?  (16) Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?  (17) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  (18) Are you presently operating under a sale and leaseback arrangement?  (19) Are you presently operating under a sale and leaseback arrangement?  (10) Was this home previously operating under a sublease agreement?  (10) Was this home previously operating under a sublease agreement?  (10) Was this home previously operating under a sublease agreement?  (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aird during this cost report period.  (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  (14) Is a portion of the building used for any function other than long term care services for her participation? For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions on Schedule V in a schedule which explains how all related costs were allocated to these functions on Schedule which explains how all related costs were allocated to these functions on Schedule vin a schedule which explains how all related costs were allocated to these functions on Schedule vin a schedule which explains how all related costs were allocated to these functions on Schedule vin a schedule vin schedule vin a schedule vin a schedule vin a schedule vin a sched	(2)	Are there any dues to nursing nome associations included on the cost report.		in the Ancillary So	ection of Schedule V!	_		
the patient census listed on page 2, Section B? No For example, action organization? No If YES, have these costs been properly adjusted out of the cost report?  4) Does the bed capacity of the building useffor from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?  (5) Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?  (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. S N/A Line  (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.  (8) Are you presently operating under a sale and leaseback arrangement. No  If YES, give effective date of lease.  (9) Are you presently operating under a sublease agreement? YES X NO  (10) Was this home previously operated by a related party and the date the present owners took over  (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report geried.  (12) Are there any salary costs which have been allocated to more than one line on Schedule V. This amount is to be recorded on line 42 of Schedule V.  (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No  If YES, attach an explanation of the location of the cost report?  No  If YES, attach an explanation of the located to manual the cost of employee meals that has been reclassified to employee benefit on Schedule V.  105 Indicate the cost of employee meals that has been reclassified to employee meals that has been reclassified to employee the fit on Schedule V.  106 Indicate the cost of employee meals that has been reclassified to employee the fit on Schedule V.  107 Indicate the cost of employee meals that has been reclassified to employee the fit on Schedule V.  108 If YES,		If YES, give association name and amount.						
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(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services			(19)	If total legal fees a	are in excess of \$2500, have legal invo	oices and a su	ımmary of serv	rices
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Attach invoices and a summary of services for all architect and appraisal fees				1	1	tect and appra	aisal fees	